SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

REQUEST FOR MEDICAID INFORMATION - COVERAGE OF EMERGENCY SERVICES

☐ FROM: ☐ TO:	☐ FROM: ☐ TO:
(Provider) ATTENTION: BILLING OFFICE	_____ Medicaid Eligibility Worker

SECTION 1 TO BE COMPLETED BY THE MEDICAID PROVIDER

Name of Individual Receiving Emergency Service: _____

Address: _____

Date of Birth: _____ SSN (if available): _____

Date of Service: _____ Nature of Emergency: _____

Person Requesting Information: _____ Location: _____

Telephone: _____ Date: _____

SECTION 2 TO BE COMPLETED BY THE MEDICAID ELIGIBILITY WORKER

Name of Individual Receiving Emergency Service: _____

Medicaid Identification Number: _____

- ☐ Is not eligible for Medicaid coverage or payment of the emergency service.
- ☐ Is eligible for payment of Medicaid claims for emergency services that were rendered during the month(s) listed below.
  Month (s) (of emergency service): _____
- ☐ Is eligible for the full range of Medicaid benefits.
  Effective Date of Eligibility: _____
- ☐ Is eligible for emergency services related to:
  (☐ *dialysis treatment* ☐ *breast and cervical cancer treatment)* beginning: _____
- ☐ Is eligible for payment of Medicaid claims related to (***pregnant woman)*** emergency services including labor and delivery **ONLY** from: _____ until 60 days after the pregnancy ends.

Signature of Eligibility Worker: _____

Location: _____ Telephone Number: _____ Date: _____